

## **§ 9792.6. Utilization Review Standards—Definitions**

(a) As used in this section:

(1) "ACOEM Practice Guidelines" means the American College of Occupational and Environmental Medicine Practice Guidelines, Second Edition.

(2) "Concurrent review" means utilization review conducted during an inpatient stay.

(3) "Insurer" means a workers' compensation insurer, a third party administrator, an employer securing its liability under subdivision (b) or (c) of Section 3700 of the Labor Code, or a designated entity.

(4) "Medical services" means those goods and services provided pursuant to Article 2 (commencing with Section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code.

(5) "Health care provider" means a provider of medical services, including but not limited to an individual provider, a health care service plan, a health care organization, or a preferred provider organization.

(6) "Prospective review" means utilization review conducted prior to the delivery of medical services.

(7) "Request for authorization" means any written or oral request for a specific course of proposed medical treatment set forth in Form DLSR 5021, Section 14006, or in the format required for Primary Treating Physician Progress Reports in subdivision (f) of Section 9785. An oral request for authorization must be immediately followed by a written request.

(8) "Retrospective review" means utilization review conducted after medical health services have been provided.

(9) "Utilization review process" means utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600. Utilization review does not include determinations of the work-relatedness of disease, or bill review for the purpose of determining whether the medical services were accurately billed.

(10) "Utilization review plan" means the written plan setting forth the policies and procedures, and a description of the utilization process.

(11) "Written" includes an electronic facsimile or electronic mail, as well as communications in paper form.

## **§ 9792.7. Utilization Review Standards—Applicability**

(a) Every insurer shall establish and maintain a utilization review process in compliance with Labor Code Section 4610. Each utilization review process shall be set forth in a utilization review plan which shall contain:

(1) The identity of the employed or designated medical director, who holds an unrestricted license to practice medicine in the state of California issued pursuant to Section 2050 or Section 2450 of the Business and Professions Code.

(2) A description of the process whereby requests for authorization are reviewed and decisions on such requests are made.

(3) A description of the specific criteria utilized in the review and throughout the decision-making process, including treatment protocols or standards used in the process. It shall include a description of the personnel and other sources used in the development and review of the criteria, and methods for up-dating the criteria. Prior to and until the Administrative Director adopts a medical treatment utilization schedule pursuant to Section 5307.27, the written policies and procedures governing the utilization review process shall be consistent with the recommended standards set forth in the American College of Occupational and Environmental Medicine (ACOEM) Occupational Medical Practice Guidelines, Second Edition.

(4) A description of the qualifications of the personnel involved in implementing the utilization review.

(b)(1) The medical director shall ensure that the process by which the insurer reviews and approves, modifies, delays, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services, complies with this section.

(2) No person, other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, may, except as indicated below, delay, modify or deny, requests for authorization of medical treatment for reasons of medical necessity to cure or relieve the effects of the industrial injury.

(3) A non-physician reviewer may be used to initially apply medically-based criteria to requests for authorization for medical services. A non-physician reviewer may delay requests for authorization of medical treatment to request additional information, but in no event the delay shall exceed the time limitations imposed in Section 9792.9 subdivisions (a)(1) through (a)(3). Any delay time beyond the time specified in these paragraphs is subject to the provisions of paragraph (5) of Section 9792.9.

(c) The complete utilization review plan, consisting of the policies and procedures, and a description of the utilization process, shall be filed by the insurer with the Administrative Director and shall be disclosed to employees, physicians, and the public upon request.

**§ 9792.8. Utilization Review Standards—Medically-Based Criteria**

(a)(1) The criteria shall be consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27. Prior to adoption of the schedule, the criteria or guidelines used in the utilization review process shall be consistent with the American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines, Second Edition.

(2) For all injuries not covered by ACOEM Practice Guidelines or by the official utilization schedule after adoption pursuant to Section 5307.27, authorized treatment must be in accordance with other evidence-based medical treatment guidelines generally recognized by the medical community that are:

(A) Developed by physicians, with involvement of actively practicing health care providers, and are peer-reviewed;

(B) Evaluated at least annually by the medical director and updated if necessary;

(3) The use of medically-based criteria shall be disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review. The insurer may not charge an employee for a copy of the relevant criteria if the copy is requested while the physician's request for medical services is under review.

(4) The medically-based criteria or guidelines used in the utilization review process shall be available to the public upon request as follows:

(A) The insurer is only required to disclose the criteria or guidelines for the specific procedures or conditions requested.

(B) The insurer may charge members of the public reasonable copying and postage expenses related to disclosing the criteria or guidelines pursuant to this paragraph.

(C) The insurer may make available the criteria or guidelines through electronic means.

**§ 9792.9. Utilization Review Standards—Timeframe, Procedures and Notice Content**

(a) The utilization review process shall meet the following timeframe requirements:

(1) Prospective or concurrent decisions shall be made in a timely fashion, not to exceed 5 working days from the receipt of the information reasonably necessary to make the

determination, but in no event shall be made more than 14 days from the date of the medical treatment recommendation by the physician.

(2) When review is retrospective, decisions shall be communicated to the individual who received services, or to the individual's designee, within 30 days of receipt of information that is reasonably necessary to make this determination.

(3) Prospective or concurrent decisions related to expedited review shall be made within 24 hours of the date of the medical treatment recommendation by the physician, but in no event shall be made more than 72 hours after the receipt of the information reasonably necessary to make the determination. Decisions related to expedited review referred to the following situations:

(A) When the employee's condition is such that the employee faces an imminent and serious threat to this or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or

(B) The normal timeframe for the decision making process, as described in paragraph (1) of this section, would be detrimental to the employee's life or health or could jeopardize the employee's permanent ability to regain maximum function.

(4) Decisions to approve, modify, delay or deny request by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to the employees shall be communicated to the requesting physician within 24 hours of the decision. Any decision to modify, delay or deny request shall be communicated to the physician initially by the telephone or facsimile. The communication by telephone shall be followed by written notice to the physician and employee within 24 hours for concurrent review and within two business days for prospective review.

(5) (A) The review must be conducted by a physician, who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice. The timeframes specified in paragraphs (1) or (2) of this subdivision may only be extended by the insurer under the following circumstances:

(i) The insurer is not in receipt of all of the information reasonably necessary and requested.

(ii) The insurer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice.

(iii) The insurer is not in receipt of all of the information reasonably necessary and requested because the insurer requires consultation with an expert reviewer.

(B) If (i), (ii) or (iii) above apply, the insurer shall immediately notify the physician and the employee, in writing, that the insurer cannot make a decision within the required

timeframe, and specify the information requested but not received, the additional examinations or tests required, or the expert reviewer consulted. The insurer may request only information reasonably necessary to determine medical necessity from a physician in order to determine whether to approve, modify, delay, or deny requests for authorization of treatment. The insurer shall also notify the physician and employee of the anticipated date on which a decision may be rendered.

(C) Upon receipt of all information reasonably necessary and requested by the insurer, the insurer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) above.

(D) Every employer insurer shall maintain telephone access from 8:00 AM to 5:00 PM Pacific Standard Time, on normal business days, and a 24-hour emergency access number for physicians to request authorization for health care services.

(b) A written decision approving a request for treatment authorization under this section shall specify the specific medical treatment service approved.

(c) A written decision to the physician modifying, delaying or denying treatment authorization under this section must contain the following information:

(1) The date on which the decision is made.

(2) The name of the reviewer, the telephone number of the reviewer, and hours of availability.

(3) A clear and concise explanation of the reasons for the insurer's decision.

(4) A description of the medical criteria or guidelines used.

(5) The clinical reasons for the decisions regarding medical necessity.

(6) State that any dispute shall be resolved in accordance with Labor Code Section 4062.

(7) Details about the insurer's appeals process, if any, and clearly state that the appeals process is on a voluntary basis as consistent with Labor Code Section 4062(a).

(d) A written decision to the injured worker modifying, delaying or denying treatment authorization under this section must contain the following information:

(1) The date on which the decision is made.

(2) A description of the medical criteria or guidelines used.

(3) State that any dispute shall be resolved in accordance with Labor Code Section 4062, and that the injured worker may file an Application for Adjudication of Claim and

Request for Expedited Hearing, DWC Form 4, showing a bona fide dispute as to entitlement to medical treatment in accordance Section 10136(b)(1).

(4) Include the following mandatory language:

*If you want further information, you may contact the local state Information and Assistance office by calling [enter district I & A office telephone number closest to the injured worker].*

*If you are not already represented by an attorney, you may also consult an attorney of your choice. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.*

(5) Details about the insurer's appeals process, if any, and clearly state that the appeals process is on a voluntary basis as consistent with Labor Code Section 4062(a).

(e) Authorization may not be denied on the basis of lack of information without documentation of a bona fide attempt to obtain the necessary information.

#### **§ 9792.10. Utilization Review Standards—Dispute Resolution**

(a) If the request for authorization of medical treatment is not approved, or if the request for authorization for medical treatment is approved in part, any dispute shall be resolved in accordance with Section 4062, except in cases involving recommendations for the performance of spinal surgery, which shall be governed by the provisions of Section 4062(b). Nothing in this paragraph precludes the parties from participating in an internal utilization review appeal process on a voluntary basis as consistent with Section 4062(a).

(b) The following requirements shall be met prior to a decision to discontinue medical treatment and to resolve disputes:

(1) In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee.

(2) Medical care provided during a concurrent review shall be care that is medically necessary to cure and relieve the effects of the industrial injury.

#### **§ 9792.11. Utilization Review Standards—Penalties**

(a) If the Administrative Director determines that the insurer has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the administrative director may assess, by order, administrative penalties for each failure pursuant to Section 10111.2 (28). These penalties shall be deposited in the Workers' Compensation Administration Revolving Fund.

**§ 9792.12. Utilization Review Standards—Medical Confidentiality Policy**

**(a) Each utilization review plan shall describe a medical confidentiality policy.**

**AUTHORITY:**

**Note: Authority cited: Sections 133, 139, 4604.5, 4610 and 5307.3, Labor Code.**

**Reference: Sections 129.5, 3211, 3702, 4062, 4600, 4603.2, 4610 and 5307.1, Labor Code.**